

Centers for Medicare & Medicaid Services, HHS

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(d) Diagnostic services furnished to outpatients by or under arrangements made by a hospital or a CAH if the services are services that the hospital or CAH ordinarily furnishes to its outpatients for diagnostic study.

(e) Diagnostic laboratory and X-ray tests (including diagnostic mammography that meets the conditions for coverage specified in § 410.34(b) of this subpart) and other diagnostic tests.

(f) X-ray therapy and other radiation therapy services.

(g) Medical supplies, appliances, and devices.

(h) Durable medical equipment.

(i) Ambulance services.

(j) Rural health clinic services.

(k) Home dialysis supplies and equipment; on or after July 1, 1991, epoetin (EPO) for home dialysis patients, and, on or after January 1, 1994, for dialysis patients, competent to use the drug; self-care home dialysis support services; and institutional dialysis services and supplies.

(l) Pneumococcal vaccinations.

(m) Outpatient physical therapy and speech pathology services.

(n) Cardiac pacemakers and pace-maker leads.

(o) Additional services furnished to enrollees of HMOs or CMPs, as described in § 410.58.

(p) Hepatitis B vaccine.

(q) Blood clotting factors for hemophilia patients competent to use these factors without medical or other supervision.

(r) Screening mammography services.

(s) Federally qualified health center services.

(t) Services of a certified registered nurse anesthetist or an anesthesiologist's assistant.

(u) Prescription drugs used in immunosuppressive therapy.

(v) Clinical psychologist services and services and supplies furnished as an incident to the services of a clinical psychologist, as provided in § 410.71.

(w) Clinical social worker services, as provided in § 410.73.

(x) Services of physicians and other practitioners furnished in or at the direction of an IHS or Indian tribal hospital or clinic.

(y) Intravenous immune globulin administered in the home for the treatment of primary immune deficiency diseases.

[51 FR 41339, Nov. 14, 1986, as amended at 52 FR 27765, July 23, 1987; 55 FR 22790, June 4, 1990; 55 FR 53522, Dec. 31, 1990; 56 FR 8841, Mar. 1, 1991; 56 FR 43709, Sept. 4, 1991; 57 FR 24981, June 12, 1992; 57 FR 33896, July 31, 1992; 58 FR 30668, May 26, 1993; 59 FR 26959, May 25, 1994; 59 FR 49833, Sept. 30, 1994; 60 FR 8955, Feb. 16, 1995; 63 FR 20128, Apr. 23, 1998; 66 FR 55328, Nov. 1, 2001; 69 FR 66420, Nov. 15, 2004]

§ 410.12 Medical and other health services: Basic conditions and limitations.

(a) *Basic conditions.* The medical and other health services specified in § 410.10 are covered by Medicare Part B only if they are not excluded under subpart A of part 411 of this chapter, and if they meet the following conditions:

(1) *When the services must be furnished.* The services must be furnished while the individual is in a period of entitlement. (The rules on entitlement are set forth in part 406 of this chapter.)

(2) *By whom the services must be furnished.* The services must be furnished by a facility or other entity as specified in §§ 410.14 through 410.69.

(3) *Physician certification and recertification requirements.* If the services are subject to physician certification requirements, they must be certified as being medically necessary, and as meeting other applicable requirements, in accordance with subpart B of part 424 of this chapter.

(b) *Limitations on payment.* Payment for medical and other health services is subject to limitations on the amounts of payment as specified in §§ 410.152 and 410.155 and to the annual and blood deductibles as set forth in §§ 410.160 and 410.161.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 33896, July 31, 1992]

§ 410.14 Special requirements for services furnished outside the United States.

Medicare part B pays for physicians' services and ambulance services furnished outside the United States if the services meet the applicable conditions

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of § 410.12 and are furnished in connection with covered inpatient hospital services that meet the specific requirements and conditions set forth in subpart H of part 424 of this chapter.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988]

§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.

(a) *Definitions.* For purposes of this section—

Detection of any cognitive impairment means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.

Eligible beneficiary means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.

Establishment of, or an update to the individual's medical and family history means, at minimum, the collection and documentation of the following:

(i) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.

(ii) Use or exposure to medications and supplements, including calcium and vitamins.

(iii) Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

First annual wellness visit providing personalized prevention plan services means the following services furnished to an eligible beneficiary by a health professional that include, and take into account the results of, a health risk assessment, as those terms are defined in this section:

(i) Review (and administration if needed) of a health risk assessment (as defined in this section).

(ii) Establishment of an individual's medical and family history.

(iii) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.

(iv) Measurement of an individual's height, weight, body-mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history.

(v) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(vi) Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

(vii) Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(viii) Establishment of the following:

(A) A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health risk assessment (as that term is defined in this section), health status, screening history, and age-appropriate preventive services covered by Medicare.

(B) A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical